CONNECTICUT HEALTH INSURANCE EXCHANGE PLANNING GRANT STAKEHOLDER MEETING AGENTS, BROKERS, PRODUCERS

DATE: May 10, 2011

LOCATION: Office of Policy and Management, 450 Capitol Avenue

INVITED TO PARTICIPATE:
Connecticut Association of Health Underwriters
Connecticut Benefit Brokers

MEETING ATTENDEES:
Robert S. Ford, RHU, Principal, E-Benefits Group Northeast, LLC
Christopher K. McKiernan, Vice President, Abercrombie, Burns, McKiernan & Company Insurance, Inc.
John C. Parker, RHU, LTCP, Owner/Principal, Parker Agency
John E. Calkins Jr., President, Bozzuto Associates Inc.
Paul E. Smith, Partner/Principal, AmeriBen Alliance, LLC
Julie Chubet, Vice President, The Benefits Group, Inc.
Stephanie DeGrandi, Partner, The HealthConsultants Group
Jesse D. McDonald, Owner/Principal, Modern Insurance
Timothy P. Tracy, Jr. Vice President, Gerard B. Tracy Associates Inc.
Phil Boyle, Vice President, The HealthConsultants Group[1]

Background

The public engagement plan for Connecticut (the State) in planning for an Insurance Exchange consists of public forums held throughout the State as well as stakeholder meetings organized by professional group category. Over 85 organizations were invited to attend a stakeholder meeting to discuss Exchange topics such as structure, operations, market reforms, accountability, transparency, and sustainability. Questions were sent to each organization prior to their meeting. The feedback the State received from these questions was used as the framework for the discussion. Meetings were conducted by a neutral facilitator and recorded/transcribed. This document reflects an integration of initial written comments from the invited organizations listed above, as well as discussion from the meeting. It is intended as a summarized snapshot of the initial perspective(s) of the groups that participated. **It is not intended to represent final thoughts or positions**.

ESTABLISH A RESPONSIVE AND EFFICIENT STRUCTURE	
Should Connecticut consider joining a multi-state Exchange?	
No.	• Each state's marketplace is different • CT has unique state-mandated benefits – CT has the third largest number of individually mandated benefits on group plans, after NY and NJ – Infertility mandates are an example in which CT has a state-mandated benefit unlike its neighboring states • CT has a unique legal structure compared to that of MA – MA carriers are not-for-profit, whereas CT is for-profit – MA has different regulations (e.g. student age on parent's plan) • CT has different rating strategies compared to NY – Small group is age and gender rated in CT, whereas in NY it is community rated • Could drive up costs for policyholders in the individual market
Should CT administer the individual and small group markets separately or jointly?	
Jointly for administrative functions.	• Merging the two Exchanges administratively will keep costs down in general and simplify the interface for the public
Separately for risk pooling.	• Separate risk pools are important to control costs – MA saw 3 to 5% increase in premiums when merged because the pools were not compatible (more illness in individual pool so employers had to take on some of that risk) – The PPACA indicates health plans must maintain a pool of claims for their in/out of Exchange plans, thus an Exchange will not have a 'pool' of all participating health plans – If the carrier does not hold the risk pool there is less of an incentive for them to manage a person's health, utilize case management, and reduce claims
What employer size should Connecticut allow into the Exchange?	
Begin with one to 50 employees in 2014.	• It is best to begin with CT's current small group definition; any other changes would require changing the law – specifically the Blue Ribbon law which currently mandates that it is one to 50 • The one to 50 and 51 to 99 markets are very different • Tackling two different markets at once will be problematic – CBIA struggles with their 51 to 99 Exchange, even though no problems with the under 50 • Might be costly in the beginning because it will take an increased amount of education to target the 51 to 99 population
Consider expansion based on experience.	• Expansion past 100 depends on what success the Exchange has during the first couple of years, but it would likely be difficult to merge larger employers into the Exchange because the 100 and larger market is very different • A company tends to select one carrier, may be self-insured, rates are lower, the rate structure is different, and whereas smaller companies don't have HR, larger companies do • A CBIA survey shows 78% of employers are under 50 lives in CT. Therefore, if you open to employers over 100, in the question arises of how many you will actually be bringing in – you are not going to get the very large companies in,

	and then you have a problem with adverse selection with the types of companies that would choose to go into the Exchange (higher risk employees with high claims) vs. being self-insured

ADDRESS ADVERSE SELECTION AND THE EXTERNAL MARKET	
Should CT allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange?	
Dual market.	• A dual market will provide the most choice by: – Continuing to make many product options available – Offering simplicity and continuity for the consumer by most closely resembling the current model • Health plans should work to offer various plan options within the four product levels available in the Exchange
Should CT implement any additional mechanisms to mitigate adverse selection?	
Do not make it too complex.	• The more complex the Exchange management and operational structure, the higher the operating cost, which will result in higher premiums • Rules need to be standardized in and out of the Exchange

SIMPLIFY HEALTH INSURANCE PURCHASE	
What issues should Connecticut consider in establishing a Navigator program?	
Navigators should be experienced.	• Navigators should have expertise in Exchange functions and coverage options • Navigators should be subject to CT's insurance licensure and continuing education requirements, as well as carry E&O insurance – If you allow Navigators to sell unlicensed, there are no protections for consumers if something goes wrong (such protections are required with Medicaid Advantage and Part D, and the long term care partnership program) – Even if Navigators are not *selling* insurance, they are giving advice to consumers about how a plan works. Thus, as with the producer's staff requiring licensure and E&O due to their interface with clients, Navigators should as well
What should Connecticut consider regarding the role of insurance brokers and agents?	
The value of their expertise.	• Agents and brokers provide many benefits. – There is a need to continue to have the option to contact a state-licensed and independent agent/broker for assistance – The value of the agent/broker to small employers is clear – The value to the agent/broker to individuals is clear – even with a website to facilitate plan comparison (insurancect.com), less than 10% buy directly without calling or emailing with questions, providing evidence of the need for brokers – for clarification or to alleviate confusion, as well as for advice on how they can enroll in Medicaid, Charter Oak, the state risk pool, and/or the new pre-existing condition insurance plan – The need will become even greater for this role with the Exchange and a need to understand subsidies • State-level Exchanges utilize the services of agents/brokers • Federal certification for brokers in the Exchange is likely • The PPACA envisions a role for agents/brokers enrolling individuals and group plans in Exchange-based products and assisting with subsidies for eligible individuals

	• Consider offering agents/brokers financial remuneration for bringing individuals eligible for pubic programs into the public coverage system through the Exchange – Brokers currently get paid an enrollment fee of $50 to enter an insured into the state high-risk pool (try something like this – a small amount for the educational effort, not a commission)

INCREASE ACCESS TO AND PORTABILITY OF HIGH QUALITY HEALTH INSURANCE	
Should CT allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should CT establish additional requirements? If additional requirements, what would you recommend? What would be the impact of those requirements?	
Balance – provide choice and make that choice meaningful.	• The standard defined in PPACA should be followed without additional limitations in order to maximize choice and competition • More plans create standardization and a more level playing field – Currently there are only four plans in both the individual and small group markets
Should CT consider establishing the Basic Health Program? What would the BHP offer as a tool to facilitate continuity of coverage and care?	
Probably not.	• It may be better for consumer to have subsidy and choice in the Exchange • People are choosy about where they will go to see a provider and who they will see. (You would want to avoid problems such as with HUSKY, where people do not use the option because of limited choices) • It may be better to have more lives in the Exchange • The BHP, if offered, should not be effective until January 1, 2014 when the newly eligible Medicaid program begins
How can CT structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)	
Automation.	• It should be completely automated, allowing for day-to-day monitoring, and up-to-date information, in the cloud – Microsoft, for example, has a system that takes data from all different legacy systems, standardizes it, and brings it back out

ENSURE GREATER ACCOUNTABILITY AND TRANSPARENCY	
What information should CT include for outreach to most effectively engage consumers? How should the information be presented?	
Provider networks is a big issue.	• The reason that one third of individuals eligible for Medicaid in CT are not enrolled is: – Their physician does not accept Medicaid – The available physician is a distance from their home – They do not like the idea of being “on welfare” (HUSKY) • Getting doctors to sign on is going to be the big issue, but it is unclear what the Exchange can do to help • The amount of personal financial data a person will have to provide in the online enrollment process will be significant. Thus, individuals should initially have access to a high level summary of these requirements

SELF SUSTAINING FINANCING	
How might the State's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange, and affect accountability, transparency and cost effectiveness?	
Costs will be passed on to consumer.	• It does not matter which business you assess, it always gets passed on to the consumer in the end. • If you just assess the four carriers likely to be in the Exchange, that is not a good incentive to be in the Exchange • Imposing fees on health plans to cover the cost of operating the Exchange will result in the health plans having to charge a higher premium for the medical insurance plans, which are the same in and out of the Exchange
What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?	
Include only essential benefits.	• It is possible that plans currently in the CT marketplace may have higher standards • We can create access, policies, and great benefits, but if people in CT cannot afford it they are not going to buy it • Medical insurance coverage is very expensive in CT; to control premiums and the cost for the state, only the essential benefits should be included • Adding benefits will make insurance more expensive for consumers and more costly for Connecticut. • Need consider what is competitive, what is affordable

ADDITIONAL EXCHANGE FUNCTIONS	
Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?	
No. Any willing provider.	• All participating health plans must meet all ACA requirements • The marketplace would lose consumer protections if 'any willing' health plan were allowed to participate
Should CT consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc)?	
No. Not beyond current rules.	• Currently standards exist for employee participation and contribution standards • Additional requirements in ACA alone will make it difficult for employers
What should be the role of the Exchange in premium collection and billing?	
None.	• The role of the Exchange is to provide information on insurance options and an on-line enrollment process. Assuming any other responsibilities will only increase the cost of the Exchange operations and make the cost of the plans more expensive
Additional Comments	
Conflict of Interest.	• Unsure where the concern about brokers originated – their job is simply to sell the products made available by the insurance companies. • Brokers need to be on the Exchange Board because they have knowledge of being in the trenches every day – the benefit is to describe their experience, help make this more cost-effective, and act as an advocate for the consumer

[1] Comment made by Phil Boyle of The HealthConsultants Group: (Stated on behalf a team member). "I did not put in point about CT having third most mandates versus NY, etc. Facts are that MN & MD have more and I think the last time I looked

we were #5 and as a follow up to this one comment, we received this information as a confirmation, "CT is #5 behind RI, MD, MN, and TX."